DO NOT SEND PROVIDER USE ONLY

VFC HOSPITAL ACTIVITY WORKSHEET

VFC PIN#		Provider Name			
Start Date		End Date			
For each child please write in the appropriate eligibility status*	Patient Identification Number (Do not use names/Soc. Security numbers)	Date of Injection	Hepatitis B	HBIG	Initials

*Indicate eligibility status by entering: <u>M</u>edicaid, <u>U</u>ninsured (No Insurance), American <u>I</u>ndian, <u>A</u>laska Native, u<u>N</u>der-insured, <u>K</u>CHIP, <u>O</u>ther, <u>P</u>rivately Insured